EXPRESS SCRIPTS®

HOME DELIVERY PHARMACY ORDER FORM

To MAIL your prescription:

1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:
   Express Scripts Home Delivery Service
   P.O. Box 66785
   St. Louis MO 63166-6785

To FAX your prescription:

1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-800-600-8105
   - **Class II prescriptions cannot be faxed.**
   - Faxes will only be accepted from a doctor's office.

PATIENT

Member ID: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

_____

E-mail: _____

Allergies: _____

_____

Health Conditions: _____

_____

_____

Over-the-Counter Medications: _____

_____

DOCTOR/PRESCRIBER

DEA: _____

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

PATIENT OPTIONS

☐ I want non-child resistant caps, when available.
☐ I want a copy of my bottle label in large print on a separate sheet of paper.

2161

Rx **First Name** _____ **Last Name** _____ **Date:** __ __ / __ __ / __ ____

Drug Name/Form/Strength	Qty	Directions for Use	Refills

X _____ Doctor/Prescriber Signature – Substitution Permissible

X _____ Doctor/Prescriber Signature – Dispense as Written

Stamped signatures cannot be accepted.

WLP785 FAX FRM Rev 03/08/2011 PBM90aCGV

H0147_15_24427_I 05/11/2015

MF-AVAD-0021-15